

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05098
195

Reg. Dist. No.

1. PLACE OF DEATH:

County Haward
 City or town Savage, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 hour -
 Hospital, institution, or street address where death occurred community 35 yrs.
Baltimore Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Haward
 City or town Minneapolis Junction
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

3. (b) Social Security Number

Graven Cleveland Blakemore

4. Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mary Gertrude Blakemore
 6.(c) If alive, give age 50-171 years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1892

8. AGE: Years 54 Months 8 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace White Park, Virginia
 (Town, county, and state)

10. Usual occupation Prognostic man

11. Industry or business U. S. Navy Yard

12. Name Graven C. Blakemore

13. Birthplace Va.

14. Maiden name Cora Stickley

15. Birthplace Va.

16. Informant Joseph W. Blakemore

Address Savage, Maryland

17. Burial Date thereof June 20, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Savage Cemetery

Location Savage, Maryland

18. Funeral director Alc. With Canalehan

Address Laurel, Maryland

19. 6/20/47 19 1947
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17th 19 47 8:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17th to June 17th

and that I last saw him alive on June 17th

Immediate cause of death _____ DURATION _____

Coronary Thrombosis 5 min.

Due to U.S. died suddenly

Due to in my office

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations L

Autopsy results L

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank Shipley, M.D.

Address Savage, Md. Date signed 6/20/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05099

Reg. Dist. No. 195

1. PLACE OF DEATH:

County Hawaii

City or town Savage
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Hawaii County Hawaii

City or town Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Nicholas George Callison

3. (b) Social Security Number

213-01-7664

4. Sex M. 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Etta Callison

7. Birth date of deceased (mo., day, yr.) November 18, 1873 6.(c) If alive, give age _____ years

8. AGE: Years 73 Months 7 Days 12 hrs. _____ min. _____

9. Birthplace Talbot County, Md.
(Town, county, and state)

10. Usual occupation Gardener

11. Industry or business Savage Mfg. Co.

12. Name Benjamin F. Callison

13. Birthplace Maryland

14. Maiden name Salah Friday

15. Birthplace Baltimore, Maryland

16. Informant Etta Callison

Address Savage Md.

17. Burial Date thereof July 2, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Savage Cemetery

Location Savage, Md.

18. Funeral director W. W. Davidson

Address Laurel, Md.

19. 6/30/47 19 1947
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30th 1947 at 3:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1st 1947 to June 30th 1947

and that I last saw him alive on June 29th 1947

Immediate cause of death Carcinoma of esophagus

Stomach

DURATION 6 mos.

Due to _____

Due to _____

Other conditions ✓

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma

apex (st.) Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank Shipley, M.D. M. D. or other _____

Address Savage, Md. Date signed 6/30/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 3 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 194

1. PLACE OF DEATH:

County HOWARD
 City or town RURAL - ELLICOTT CITY
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 YRS.
 Hospital, institution, or street address where death occurred:
TRIADDELPHIA ROAD
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County HOWARD
 City or town RURAL - ELLICOTT CITY
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. TRIADDELPHIA ROAD
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

FANNIE JOHNSON

3. (b) Social Security Number

4. Sex F 5. Color or race C 6. (a) Single, married, widowed, or divorced WIDOWED
 8. (b) Name of husband or wife EDWARD JOHNSON
 7. Birth date of deceased (mo., day, yr.) APRIL 2, 1870 8. (c) If alive, give age - years
 8. AGE: Years 77 Months 2 Days 8 It less than one day - hrs. - min.

9. Birthplace HOWARD CO., MARYLAND
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name JOHN BURGESS13. Birthplace HOWARD CO., MARYLAND14. Maiden name UNKNOWN15. Birthplace HOWARD CO., MARYLAND16. Informant LEWIS JOHNSONAddress 1717 EDMONDSON AVE., BALTO.

17. BURIAL Date thereof JUNE 13, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory BROWN'S CHAPELLocation DAYTON, MD.18. Funeral director KATE WILLIAMSAddress 321 STROWDER ST., BALTO.

19. June 11 19 47
 (Date rec'd by registrar) Registrar Marie C. Whitaker

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 10, 1947 at 11:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 25, 1947 to JUNE 9, 1947
 and that I last saw her alive on JUNE 9, 1947

Immediate cause of death

DURATION

CEREBRAL HEMORRHAGE 2 weeksDue to HYPERTENSION 10 yearsDue to ARTERIOSCLEROSIS 20 years

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles S. Whitaker, M.D. M. D. or otherAddress CLARKSVILLE, MD. Date signed 6-11-47

RECEIVED
JUN 13 1947
BUREAU V.S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 191

1. PLACE OF DEATH: Smith Hill - Edw. H. City Honor Co. Md.
 (a) Baltimore City, Maryland
 (b) Street address
 (c) Hospital or institution
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State md. (b) County Howard
 (c) City or town Ellicott City, Md.
 (If outside city or town limits, write RURAL and give town)
 (d) Street No.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country.

3 (a) FULL NAME Montford Lawson
 3 (b) If veteran, name war No. 3 (c) Social Security Account No.

4. Sex m 5. Color or race C 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Jennie
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1984

8. AGE: Year 62 Months 6 Days 2 If less than one day hr. min.

9. Birthplace Burgina
 (town, county, and state)

10. Usual Occupation Labour

11. Industry or business

FATHER 12. Name James Lawson
 13. Birthplace Va

MOTHER 14. Maiden Name Ellie Wade
 15. Birthplace Va.

16 (a) Informant Jeanette Lawson
 (b) Address Ellicott City Md.

17 (a) Burial (b) Date thereof 7-2-47
 (Burial, cremation, or removal) (month) (day) (year)
 (c) Cemetery or crematory Western Star
 Location Catonville Md.

18 (a) Funeral director F. C. Huginbottom
 (b) Address Ellicott City Md.

19 (a) July 1, 1947 (b) John P. Longman
 (Date rec'd by registrar) (Registrar)
P. G. E. L.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27-47, at 3:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. McNeil M.D.

Date signed 6-28-47 Medical Examiner.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 120

1. PLACE OF DEATH:

County: Howard
 City or town: Rural - Waterloo
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Motorist traveling
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State: Md County: Baltimore
 City or town: 810 Madison Ave
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: 2nd world war
 (If rural, give LOCATION)
 2.(a) If veteran, name war.

3. (a) FULL NAME

Harold Reeves Miller

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept 17, 1926

6. (c) If alive, give age years

8. AGE:

20

8

21

hrs. min.

9. Birthplace

Baltimore Md

10. Usual occupation

Bleeding & repairing

11. Industry or business

Student

12. Name

Phillip

13. Birthplace

Russia

14. Maiden name

Sophie

15. Birthplace

Russia

16. Informant

Phillip Miller

Address

810 Madison Ave

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

6-10-47

Cemetery or crematory

Rosedale

Location

Phila Rd & Hamilton Ave

18. Funeral director

Jack Lewis Inc

Address

1409 E Balto St

19. (Date recd by registrar)

6/9 47

19. 47

Sw Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 8 1947

at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 8 1947 to June 8 1947

and that I last saw him alive on at no time

Immediate cause of death

Compound fracture of skull

DURATION

Inst.

Due to

Automobile accident

Due to

Automobile accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6-8-47

Where did injury occur? Rural Waterloo Howard Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Street

Means of injury auto accident Injured at work? no

Signature Alpha M. Herbert MD

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other

Address Ellwood City Md Date signed 6-8-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 180 05103 190

1. PLACE OF DEATH:

County Howard

City or town 6004 Old Washington Rd.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Howard

City or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6004 Old Washington Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

WILHELMINA MONTGILLION

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

B.(b) Name of husband or wife Charles E. Montgillion

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1872 6.(c) If alive, give age years

8. AGE: Years 74 Months 6 Days 7 If less than one day hrs. min.

9. Birthplace Elkridge, Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Conrad Zink

13. Birthplace Germany

14. Maiden name Mary Weaver

15. Birthplace Unknown

16. Informant Miss Justa Montgillion

Address 177 Oaklee Village

17. Burial Date thereof 6/28/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Grace Episcopal Cem.

Location Elkridge, Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. June 28 1947 (Date rec'd by registrar) APC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-26 19 47 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-26 19 47 to 6-26 19 47 and that I last saw her alive on no date 19 47

Immediate cause of death Suffocation

DURATION

instant

Due to 2nd Burns - entire body

instant

Due to

Other conditions none

(Include pregnancy within 8 months of death)

Major findings of operations none Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6-26-47

Where did injury occur? Elkridge (City or town) Howard (County) Md. (State)

Injured at home, farm, industry, public place (where?) home

Means of Injury House fire Injured at work? no

23. SIGNATURE George E. Burdick M.D. M. D. or other

Address Elkridge City Date signed 6-26-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05104

Reg. Dist. No. 190

1. PLACE OF DEATH: Howard
 County.....
 City or town..... Elkridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
6507 Old Washington Blvd.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
Md.
 State..... County.....
 City or town..... Elkridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6507 Old Washington Blvd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
HARRY D. OGLE

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) Feb. 11, 1869
 8. AGE: Years 78 Months 4 Days 3 If less than one day
 hrs. min.

9. Birthplace Prince George Co., Md.
 (Town, county, and state)
 10. Usual occupation retired
 11. Industry or business B. & O.
 12. Name Richard L. Ogle
 13. Birthplace Prince George Co., Md.
 14. Maiden name Fannie D. Knight
 15. Birthplace Domeiston, Vermont

16. Informant Mr. M. B. Ogle
 Address 6507 Old Washington Blvd.
 17. Burial 6/18/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Loudon Park Cem.
Balto., Md.
 Location.....
 18. Funeral director WM. J. TICKNER & SONS
 Address Balto., Md.
 19. 6/17 47 A. H. Hedrick
 (Date rec'd by registrar) (year) (month) (day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 14, 19 47 at 8:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 11 19 45 to June 14 19 47
 and that I last saw him alive on June 13 19 47

Immediate cause of death.....
Chronic myocarditis 2 yrs
compensation 2 yrs
 Due to bronchitis 10 yrs
 Due to general arteriosclerosis 17 yrs
 Other conditions Senility
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE B. B. Brumby M. D. or other
 Address Elkridge, Md. Date signed 6/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05105

Reg. Dist. No. 191

1. PLACE OF DEATH:

County NewwardCity or town Ellisville City Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County NewwardCity or town Ellisville City (Rural)
(If outside city or town limits, write RURAL and give nearest town)Street No. Watkins Road
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Lara May Ruse

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife R. Walton Ruse

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Mar. 28, 1878

8. AGE:

Years

Months

Days

If less than one day

6925

hrs.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation at home

11. Industry or business

FATHER
MOTHER12. Name Norace P. Wilson13. Birthplace md.14. Maiden name Mary C. Wilson15. Birthplace md.16. Informant R. Walton RuseAddress Ellisville City md.17. Burial Date thereof 6-5-47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. MarksLocation Wig Island18. Funeral director W.C. WignimbathamAddress Ellisville City md.19. June 5 19 47 John B. Loughran
(Date rec'd by registrar) (year) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 19 47 at 10:45 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-1 19 47 to 6-3 19 47
and that I last saw h. alive on 6-3 19 47

Immediate cause of death

Cornary Thrombosis

DURATION

24 hoursDue to arterio-sclerotic C.V.D.4 mo.

Due to

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George E. Bunting M.D.

M. D. or other

Address Ellisville City md. Date signed 6-4-47

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JUN 9 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the addition of residence is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 926

05106

FILE NO. G 110 JUN 18 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 193

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Joseph Allen Sands.

3. (b) Social Security Number

4. Sex

M

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife.....

Florence Sands

7. Birth date of deceased (mo., day, yr.)

Oct. 1. 1868

6. (c) If alive, give age..... years

8. AGE:

Years 78

Months 8

Days 7

If less than one day

hrs.

min.

9. Birthplace.....

Howard Co.

(Town, county, and state)

10. Usual occupation.....

labor

11. Industry or business.....

FATHER

12. Name.....

Denise Donah

13. Birthplace.....

unknown

14. Maiden name.....

unknown

15. Birthplace.....

unknown

16. Informant.....

Alexander Donah

Address.....

Cooksville

17.

(Burial, cremation, or removal, Which?)

Date thereof.....

June 9, 1947

Cemetery or crematory.....

Bush Park

Location.....

near Cooksville

18. Funeral director.....

H. M. Snyder

Address.....

mt. Airy md

19.

(Date rec'd by registrar)

1947

E. Paul Spencer

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

6-7-47

19.....

at 925 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-2-

1947, to 6-7-

1947

and that I last saw him alive on 6-7-47

Immediate cause of death.....

Mitral Insufficiency?

Due to.....

Arterio-sclerotic

Due to.....

Heart Disease

Other conditions.....

Nephritis.

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

C. F. Maloney-M.D.

M. D. or other

Address.....

Cooksville, Md.

Date signed.....

6-7-47

841

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JUN 14 1947

BUREAU 76

June 14 1947 76 -2-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05107 195

1. PLACE OF DEATH:

County Howard Co.
 City or town Laurel (North Laurel)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 week
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr George
 City or town Laurel
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles Isaac Seaggs

3. (b) Social Security Number

577-20-6488

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Single
 8. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Oct. 1903
 8. AGE: Years 43 Months 11 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Seaggsville, Howard, Md.
(Town, county, and state)10. Usual occupation Groom11. Industry or business Race track12. Name Thomas Bradley Seaggs13. Birthplace Maryland14. Maiden name Mary E. Grimes15. Birthplace Rockland, Howard Co. Md.16. Informant Joseph D SeaggsAddress 323 Ridge Rd, Greenbelt, Md.17. Buried Date thereof June 21, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Good Shepherd Cem.Location Rockland, Md.18. Funeral director De W. W. DonaldsonAddress Laurel, Maryland6/20/47 19 _____
(Date rec'd by registrar)19. _____
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1947 at 4 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18, 1947 to June 18, 1947 and that I last saw him alive on at his home 19 _____

Immediate cause of death _____

DURATION

Carcinoma of lungs 2 yrsDue to _____
(note: phone call to Dr. Herbert 7-1-47:Due to Dr. Herbert did not see deceased alive; saw him for first time June 18, 1947. PRC-I.Other conditions Chronic alcoholism

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Alpha M Herbert MD

DEPUTY CLERK OF THE CLERK OF THE COUNTY M. D. or other

Address Ellicott City, Md. Date signed 6/18/47

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JUN 24 1947

BUREAU 88

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

CERTIFICATE OF DEATH

Reg. Dist. No. 05108 195

1. PLACE OF DEATH:

County HOWARD COUNTY
City or town SAVAGE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? transient
Hospital, institution, or street address where death occurred:
Washington Blvd at Savage Md. Bridge
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County FREDERICK
City or town FREDERICK
(If outside city or town limits, write RURAL and give nearest town)
Street No. 112 WEST 5th ST.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

BEATRICE ELLEN TALBERT

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced SINGLE

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) FEB. 19, 1928. 6. (c) If alive, give age years

8. AGE: Years 19 Months 3 Days 25 If less than one day hrs. min.

9. Birthplace FREDERICK, Md.
(Town, county, and state)

10. Usual occupation AT HOME

11. Industry or business

12. Name FERNANDO TALBERT

13. Birthplace FREDERICK COUNTY, Md.

14. Maiden name MARY LOUISE CLEM.

15. Birthplace FREDERICK COUNTY, Md.

16. Informant FERNANDO TALBERT

Address 112 WEST 5th ST, FREDERICK, Md.

17. BURIAL Date thereof JUNE 17, 1947.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory MT OLIVET CEMETERY

Location FREDERICK, Md.

18. Funeral director J. ARTHUR WALTERS.

Address 505 WASHINGTON BLVD., LAUREA, Md.

19. 6/15/47 19 1947 Frank Shipley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 15, 1947 at A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15, 1947 to June 15, 1947
and that I last saw him alive on at no time 19

Immediate cause of death Compmin Fracture of Skull at base of brain DURATION Inst.

Due to automobile accident

Due to

Other conditions Fracture of Left femur

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6-15-47

Where did injury occur? Savage Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public road

Means of injury Auto accident Injured at work? no

23. SIGNATURE Clifford M. Herbert MD M. D. or other

Address Ellicott City Md Date signed 6-15-47
Dr. Clifford M. Herbert for Howard Co.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUN 18 1947
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JUN 18 1947
BUREAU OF INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 193

1. PLACE OF DEATH: Howard Co.
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME Charles A. Warner

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Lara Warner
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) April 1 1870
8. AGE: Years 77 Months 2 Days 25 It less than one day..... hrs. min.

9. Birthplace Howard Co
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
12. Name David Warner
13. Birthplace Unknown
14. Maiden name Barney Dyer
15. Birthplace Unknown

16. Informant Charles Warner
Address Int. City and
17. Burial Date thereof June 28, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Poplar Spring
Location M. Poplar Spring
18. Funeral director H. M. Swales
Address Int. City
6-27-47 19. E. Paul Quinn
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947 at 6 58 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1947 to June 25 1947
and that I last saw him alive on June 25 1947
Immediate cause of death Cerebral Hemorrhage DURATION 5 days
Due to Hypertension
Due to
Other conditions
(Include pregnancy within 8 months of death)
Major findings of operations..... Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE C. M. Han M. D. or other not aing
Address..... Date signed 6-26

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

